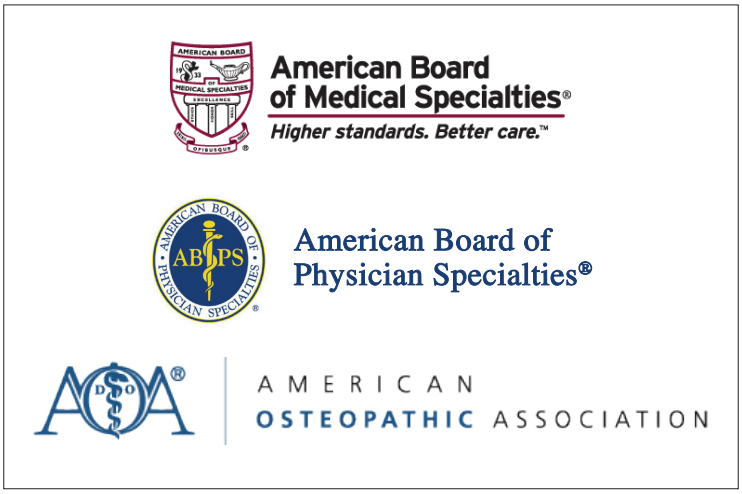
A Short Guide to the Specialty Certification of Physicians

by Todd Sagin, M.D., J.D.

This brief monograph is intended for multiple audiences who have an interest in understanding how physician specialty certification is determined and utilized in the United States. Certification by medical specialty boards has become an increasingly important indicator of physician competency as concerns about healthcare quality have escalated in recent decades. For the public, board certification is often used as a proxy of physician quality. For physicians, board certification is an essential criterion for medical privileges at many hospitals and is under consideration as a requirement for licensure in some states. Board certification is also a criterion for participation in some payer networks, considered by medical school promotion committees, and a requirement in many instances for the selection of physicians to be GME program directors.



The efficacy of modern medicine has grown and there has been a concurrent proliferation of organizations that claim to represent specialty organizations with the ability to "certify" the expertise of practitioners. Some of these organizations represent multiple specialty boards and are national in scope. These organizations often sponsor intensive efforts to strengthen and validate their certifying activities. Other certifying bodies are limited to a single specialty, have a more limited scope of activity, and bring fewer resources to bear on their efforts to assess specialty expertise. Some organizations are widely recognized by licensing bodies and major health care organizations, while others are not. This creates a confusing mélange of resources for individuals and health care bodies seeking information on the abilities of physicians in various specialties. To complicate things further, the evidence-based literature that reflects on the efficacy of 'board certification' is relatively sparse.

Given the growing importance of specialty certification, it is not surprising that there are many voices making various claims about who should certify physicians and what certification actually represents. This monograph is meant to be a guide through the cacophony.

A Brief History of Medical Specialty Certification in the United States

Early Formation of Specialty Organizations

Throughout most of history, doctors have tended to be generalists who provided care that ranged from delivering babies and treating infections to performing surgery. However, the beginning of the 20th century saw rapid advances in medical care that spawned a rise in physician specialization. The increasing technical nature of new areas of practice that accompanied the expansion of medical knowledge attracted many physicians to focus on the satisfaction of mastering a single field. This appeal was reinforced by the shorter hours, fewer house calls, and greater prestige and income that accompanied specialization.

Edward A. Jackson (1856-1942)
Major contributor to the establishment
of the first specialty medical board (Ophthamology).

Initially, any physician could claim status as a 'specialist'. However, in his seminal history of American health care, The Social Transformation of Medicine, the author Paul Starr notes … "World War I accentuated the sense that specialty practice needed standards. In its examinations of physicians who claimed to practice a specialty, the military found many unqualified. Of the ophthalmologists, for example, 51 percent were rejected."[1]

The period immediately after WWI saw more and more doctors taking short postgraduate courses and calling themselves specialists. One response to this unregulated environment was the establishment of the medical residency system as the recognized pathway to specialization.[2]

As doctors began to narrow the focus of their care to specific areas of clinical medicine, they developed professional specialty groups to support their work. These 'professional societies' and medical education institutions encouraged the development of 'boards' to define specialty qualifications and to issue credentials that would assure colleagues and the public of the specialists' qualifications. The concept of a specialty board was first proposed in 1908 by Dr. Derrick T. Vail, Sr. in his presidential address to the American Academy of Ophthalmology and Otolaryngology. As a result of his recommendations and the persistent efforts of Edward M. Jackson, M.D., the American Board for Ophthalmic Examinations was chartered in 1917.[3]

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[1] See *The Social Transformation of Medicine* by Paul Starr, pg. 224.

[2] An excellent reference on this development is Kenneth M. Ludmerer's, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*.

[3] This specialty board officially changed its name to the American Board of Ophthalmology in 1933. For information on Drs. Vail and Jackson see, *Archives of Ophthalmology*, Feb 2012; 130(2):224-32

The second specialty board to formally organize was the American Board of Otolaryngology established in 1924. Since that time there has been a steady proliferation of specialties and specialty boards. The third and fourth organized specialty boards were the American Board of Obstetrics and Gynecology (1930) and the American Board of Dermatology and Syphilology (1933).[4] The intent of these boards was summed up in an editorial in the American Medical Association's Archives of Dermatology in 1933, which extolled the value of a newly established board in dermatology as follows:

> *"…the Board will undoubtedly gain quickly the recognition of the profession and will become in effect the licensing board of dermatologists in the United States. This is an end much to be desired. One of the things that is not needed in medicine is more confusion in medical education, such as would be caused by the states undertaking to set up standards for specialists. Volunteer certifying boards like the Board of Dermatology seem to be the proper solution of certification of specialists. This board has the confidence and the best wishes of the ARCHIVES."*[5]

Advocates for such boards saw them as beneficial in numerous ways beyond merely issuing certificates of qualification. They argued that boards could be utilized to elevate the standards of clinical practice in specialty niches; educate the public and other professionals about the growing capabilities of specialists; protect the public from unqualified practitioners; set requirements for education and training in specialty medicine; develop educational resources for the preparation of specialists; and provide oversight of examination processes tied to the granting of specialty certification.

Advocates of Specialty Boards Identified Numerous Benefits:

- Elevation of standards of clinical practice in specialty niches
- Education of the public and other professionals about the growing capabilities of specialists
- Protection of the public from unqualified practitioners
- Establishment of requirements for education and training in specialty medicine
- Development of educational resources for the preparation of specialists
- Provision of oversight of examination processes tied to the granting of specialty certification

In these early decades of the twentieth century attention focused on creating a certifying agency in every specialty of medicine and surgery and an advisory board to consult on these activities. The development of such certifying boards was aided by the National Board of Medical Examiners (NBME) in May 1932 through the formation of a 'Committee on Specialists'. The purpose of this committee was to present suggestions for establishing national qualifying boards in medical specialties. In 1933 representatives from several specialty sections of the American Medical Association, the Association of American Hospitals, the Association of American Medical Colleges, the Federation of State Medical Boards of the United States, the American Medical As-

[4] Arch Derm Syphilol. 1933;27(3):505
[5] Ibid.

sociation's Council on Medical Education and Hospitals, and the National Board of Medical Examiners formed an advisory council to serve as a forum for the discussion of problems common to the various specialty examining boards in existence or being considered in medicine and surgery. The formal organization of the Advisory Board for Medical Specialties took place at a meeting in Boston in September of 1933 and bylaws and a constitution were adopted in February of 1934.[6] Further efforts at formalizing the recognition of specialty boards occurred in 1948 with the establishment by the AMA and the Advisory Board for Medical Specialties of the Liaison Committee for Specialty Boards (LCSB). The LCSB was created to receive applications for approval of new medical specialty certifying boards and make recommendations on these applications to its parent organizations. At the time the LCSB was founded the Liaison Committee recognized 18 specialty boards.

> "Announcement is made of the formation of the Advisory Board for Medical Specialties... The Advisory Board should have an influence on undergraduate medical education as well as on graduate education in the specialties... and in effecting a general improvement in the standards of practice in the various specialties."
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> Notice in the *Journal of the American Medical Association*, April 21, 1934

The Rise of Subspecialty Medicine

Medical research and the development of new clinical practices took another spurt during WWII and in the years immediately following. An explosion of new medical knowledge and technology spawned an increasing number of specialties and a rapid rise in the number of specialists. The 1960s and 1970s saw a significant rise in the number of requests to the Advisory Board for Medical Specialties by organizations wishing to be recognized as a specialty board. During this time the concept of subspecialty certification took hold and many boards began to grant subspecialty certificates. The significance of specialty certification began to be appreciated by an ever growing body of health care institutions, the concept marketed to the public, and the movement supported by an ever more complex educational establishment focused on graduate medical education. By the 1970s and in the decades since, the proliferation of certifications has generated a confusing nomenclature of terms: e.g. general certification, initial certification, primary certification, special certification, subspecialty certification, certificates of added qualifications, certificates of special qualifications, and more. Organizations granting certification have had to struggle over the years with numerous difficult and often controversial questions. For example,

- Does the creation of too many subspecialties fragment the effectiveness of primary specialty boards?
- Should specialists be required to receive general training prior to sub-specialization, and if so, how much?
- What are appropriate eligibility requirements for specialty residency training programs?
- Who should create the standards for specialty residency training?
- Should there be a 'preceptor' path to specialty certification in lieu of specialized residency training?
- Should specialty residency training occur only in academic institutions and if not, what community settings are adequate?

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[6] See the website of the American Board of Medical Specialties

- What are adequate examination procedures?
- Should certification reflect training and education or current competence?
- What status should training outside of the United States be given?

While consensus has been reached on some of these questions, many are still areas of contention now in the second decade of the 21st century. The past fifty years has also seen a proliferation of organizations offering specialty certification. Some have been short-lived and clearly self-serving, while others have grown into substantial entities that have achieved broad recognition for the quality of their work. A partial description of the most prominent specialty certification organizations can be found later in this monograph.

Certification, Renewal of Certification, Maintenance of Certification, and Subspecialty Certification

As medical knowledge and technology continue their rapid expansion, physicians have continued to narrow the focus of their expertise in subspecialty silos. In response, specialty boards have identified subspecialty domains in which they choose to issue additional certification. Many doctors have a general specialty certification, as well as one or more subspecialty certifications. For example, a physician might hold board certification in Psychiatry with additional subspecialty certification in Child and Adolescent Psychiatry. Some boards augment their general grants of certification by issuing eligible individuals with 'certificates of added qualifications' (CAQs). In addition, there are no restrictions on a physician holding board certification in more than one general specialty as long as she meets the criteria established by each board. For instance, a doctor may be board certified in both internal medicine and in pediatrics.

Over the past decades many specialty boards have been widely recognized for the rigorous requirements established for certification in their area of expertise. For example, testing has gotten more sophisticated based on rigorous evidence in the educational literature. Initially, grants of certification from specialty boards were not time limited and did not have to be renewed. However, given the rapid rate at which medical science advances, 'once-in-a-lifetime' certification is hard to justify. The American Board of Family Practice (ABFP), founded in 1969, was the first specialty board to grant time limited certification.[7] The ABFP administered its first recertification exams in 1976 and other specialty boards began to follow suit by the 1980s. Recertification requirements vary by specialty, but those issuing time-limited certification generally require re-examination every six to ten years. The stated purpose of recertification has been to ensure physicians engage in continuing medical education and examination to maintain competency in their given specialty.

A new approach being advocated by some certifying organizations is 'maintenance of certification' (MOC). This approach requires physicians to engage in ongoing education and clinical experience in-between testing for re-certification. Specialty boards that have chosen to pursue this approach are implementing maintenance of certification standards at differing rates. In general, these new MOC requirements are based on evidence-based guidelines, national standards and best practices in combination with customized continuing education that demonstrates mastery of specialty subject matter. Advocates of MOC argue it will benefit physicians because it drives focused learning based on individual practice needs, may reduce malpractice premiums, can reduce duplicate demands for evidence of competence from credentialing bodies, and can be used to market the quality of a physician's care. However, the approach has vocal detractors who see maintenance of certification as burdensome requirements imposed on physicians to meet the growth

[7] In 2005 this board was renamed the American Board of Family Medicine.

demands of sponsoring organizations. As one commentator in the New England Journal of Medicine noted, the MOC process "fall short in terms of relevance and the time, effort and expense it requires of candidates."[8,9] In part because of physician concerns raised over maintenance of certification, different certifying bodies are taking somewhat different approaches to continuous assessment of specialty competency. The American Board of Medical Specialties refers to their efforts as 'Maintenance of Certification (MOC)'. The American Board of Physician Specialties labels their efforts as 'Continuous Competency in Certification (CCC)'. The American Osteopathic Association's nomenclature for this approach to certification is 'Osteopathic Continuous Certification (OCC)'.

Over the years there have been ongoing pockets of physician resistance to evolving requirements for board certification. Many physicians have chosen not to comply with the requirements to maintain or renew their board certification designation.[10] The reasons vary and include the burden of preparing for examinations, the expense involved, nonbelief in the value of ongoing certification, or the proximity to retirement.[11] However, this resistance continues to fall away as younger generations of physicians, more accustomed than their older peers with new practice evaluation methodologies, come to expect that board certification will become an ongoing requirement in their professional careers.

The Connection Between Licensure and Specialty Certification

State licensure is the dominant method of regulating the medical profession. Licensure is a grant of official permission to an individual or business to engage in a specific activity. States define the scope of medical practice through statutes and regulations and they discipline practitioners who are noncompliant. While specialty certification in the United States is a voluntary process, a physician must possess a license to practice medicine in any state. The process of medical licensure is not specialty specific and it sets the minimum competency requirements to diagnose and treat patients. This license typically results in unrestricted permission to exercise medical practice in any specialty area. Thus, being licensed does not indicate whether a doctor is actually qualified to practice in a particular medical specialty.

> Board certification is widely recognized as an important quality marker by hospitals, insurers, credentialing and patient safety organizations, governments, and the public.

The Federation of State Medical Boards (FSMB) is a non-profit organization that represents the nation's 70 state medical boards.[12] In recent years, FSMB has demonstrated growing interest in linking licensure and re-licensure to demonstration of clinical competence. This concern stems from a growing number of studies (e.g. from the Institute of Medicine and the PEW Commission) that suggest the health care system could be safer if this were the case. It also is driven by growing public demand for greater accountability by state medical boards.

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[8] Goldman L, Gorrol AH, Kessler B. Do not enroll in the current MOC program. *NEJM*, 2010;362:950-952.

[9] For a thoughtful discussion of the strengths and weaknesses of Maintenance of Certification see, Ensuring Physician's Competence –Is Maintenance of Certification the Answer, by John K. Inglehart and Rober Baron, M.D. in *NEJM*, 2012; 367(27): 2543-9

[10] Lipner R, Bylsma W, Arnold G, Fortna G, Tooker J, Cassel C. Who is Maintaining Certification in Internal Medicine – and Why? A National Survey 10 Years after Initial Certification. *Annals of Internal Medicine*. 2006; 144(1):29-36

[11] Drazen J, Weinstein D. Considering Recertification. *NEJM*. 2010; 362(10):946-947

[12] Many states have both an allopathic and an osteopathic medical board. Recognized state medical boards and their addresses can be found on the FSMB website at www.fsmb.org/directory_smb.html

The FSMB has had ongoing discussions regarding the implementation of 'Maintenance of Licensure' (MOL). The organization characterizes MOL as "a process by which licensed physicians periodically provide, as a condition of license renewal, evidence that they are actively participating in a program of continuous professional development that is relevant to their areas of practice, measured against objective data sources and aimed at improving performance over time."[13]

In 2010, after seven years of study, the FSMB adopted a general framework for MOL that acknowledges the need for lifelong learning and is based on the general competencies for physicians identified by the American College of Graduate Medical Education (ACGME).[14] Nevertheless, the FSMB is still years away from adopting specific requirements for maintenance of licensure. It is likely that any requirements the FSMB finally establishes will recognize the importance of certification status by specialty certifying boards.[15]

Board Certification and Hospital Privileges

In order to practice medicine in a hospital in the United States, a physician must be granted the right to do so by the institution's governing board. Every hospital must adopt formal processes for vetting the credentials of physicians who wish to practice in its facilities. In addition, the hospital must make explicit determinations of what clinical activities it will allow a physician to perform based on an assessment of that practitioner's current competency.

Each hospital gets to establish its own criteria for medical staff membership and privileges. As it became customary for physicians completing residency training to take certification exams in their specialty area, many hospitals began to make board certification an eligibility requirement for staff membership and/or privileges. While accurate data on board certification requirements is not available, it appears that a majority of the nation's thousands of hospitals require an initial applicant for staff membership and/or privileges to be board certified in at least one specialty area or to be in the process of becoming board certified. Many hospitals have also implemented requirements that members of their medical staff *maintain* their board certification. At the time they adopted these standards, most hospitals have allowed current staff members an exemption from the newly imposed board certification requirements. As a result, many medical staffs lack uniformity in the certification status of their physician staff.

In an increasingly competitive healthcare world, hospitals frequently post or advertise the extent to which their medical staff is board certified as a marketing strategy. Organizations that rate the quality of hospitals often report the percent of staff board certified as a marker of superior quality.

While board certification can be used to establish eligibility for medical staff membership, it can also be used to establish criteria to hold specific clinical privileges. For example, a physician may be granted staff membership as a result of being boarded in internal medicine, but rejected for privileges in the catheterization lab because he or she does not hold certification in cardiology. The use of specialty board certification as criteria to hold a specific privilege or cluster of privileges is on the rise in healthcare institutions across the country.

Despite the rising use of board certification criteria by hospital credentialing bodies, it remains clear that specialty boards are more aggressive than hospitals in establishing higher standards for physicians who provide care. In this regard, organizations of specialty boards in the United States have

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[13] see the FSMB website at www.fwmb.org/pdf/mol-faqs.pdf

[14] These general competencies are: medical knowledge, patient care, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems based practice.

[15] The research underpinning the move to MOL is summarized in the following article: Chaudhry, Cain, Staz, et. al., The Evidence and Rationale for Maintenance of Licensure, *Journal of Medical Regulations*, Vol. 99, No.1, p. 19

assumed a clear leadership role in addressing the nation's deficits in patient safety and health care quality.

The Rationale and Evidence Justifying Specialty Certification

The historical premise of specialty certification has been that a certain constellation of education and training is required to be able to perform with reliable quality in a specialized area of medicine. As specialty boards became more sophisticated the addition of testing assured that this education and training actually resulted in acquisition of the requisite specialty knowledge base. Many boards also added an experiential requirement – a defined period in which specialty knowledge and skills were actually exercised – in order to provide evidence of actual competency in the performance of specialty medicine. In recent decades many specialty boards have focused on periodic recertification requirements to assure the public and the profession that board certification actually reflects current – rather than historical – competence in their area of specialization. The most recent manifestation of this effort is the trend to require 'maintenance of certification' – an ongoing set of requirements that must be fulfilled in order to maintain the 'board certified' designation. The attention to demonstrating ongoing competence has been given impetus from ongoing studies which show that physicians may develop deficits in critical skills and knowledge the further away they get from the rigors of their residency training.[16]

To add to the credibility of their work, many boards or organizations that support them have made significant investments in improving the scientific rigor underpinning their testing methodologies, utilizing the latest educational research and testing technologies. New modalities for testing have been introduced, from the deployment of computers to the use of sophisticated simulation laboratories and patient actors.

Despite the increasing rigor of certification requirements there have always been skeptics who challenged the belief that such requirements were actually linked to better clinical outcomes for patients. A growing body of evidence-based literature is beginning to demonstrate a clearer connection between the testing of certification bodies and the ability to predict higher levels of clinical performance. For example, recent research has provided evidence that: board certified physicians provide care to patients with acute myocardial infarction consistent with national guidelines more often than their noncertified counterparts; board certification is associated with higher rates of preventive services in the Medicare population; certification in surgery is a significant predictor of lower mortality and complication rates for colorectal surgery; and physicians who are not board certified are more likely to have been subject to professional disciplinary action.[17]

While the evidence demonstrating that board certified physicians provide higher quality care than their noncertified counterparts is growing, it is far from conclusive. Critics have pointed to the poor quality of many of the studies conducted to date. Nevertheless, the more rigorous studies have been supportive of a link between board certification and quality.[18] It is clear that more rigorous study in this area is necessary and will become more essential as hospitals and regulatory bodies increase their reliance on certification as a proxy for current competence.

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[16] Caulford PG, Lamb SB, Kaigas, TB, et.al. Physician Incompetence: Specific Problems and Predictors, Academic Medicine. 1994;69(10): p.16-18
Choudry NK, Fletcher r. Systematic Review: The Relationship between Clinical Experience and Quality of Health Care. Ann Internal Med. 2005; 142(4): 260-273
Eva KW. The Aging Physician: Changes in Cognitive Processes and Their Impact on Medical Practice. Academic Medicine. 2002; 77(10)(suppl.)S1-S6

[17] References regarding research on the connection between board certification and improved clinical outcomes can be found in the bibliography accompanying this monograph.

[18] Sharp LK, Bashook PG, Lipsky MS, Horowitz SD, Miller SH. Specialty board certification and clinical outcomes: the missing link. Acad Med. 2002;77(6):534-52

Legal Ramifications of Certification

Board certification is the process by which a physician (or other medical practitioner) demonstrates through written, practical, and/or actual practice or simulator based testing, a mastery of the basic knowledge and skills that define a particular area of medical specialization. As such, plaintiff attorneys frequently claim that a non-certified physician is not competent and should not have treated injured patients who are their clients. While board certification is not a definitive marker of physician competence, its widespread recognition is making it a de facto standard for this determination. Physicians that fail to become board certified and organizations that do not insist on certification as a credentialing requirement will be increasingly vulnerable to the allegations by plaintiff attorneys that malpractice occurred.

Descriptions of the various organizations that certify physicians in specialty practice

Today there are hundreds of organizations that claim to validate the expertise of physicians in specialty areas of medicine. Each of these organizations is a private entity with a unique history that underpins its formation. The proliferation of such organizations makes a comprehensive description or complete listing impossible for this brief monograph. However, there are three primary entities in the United States which oversee the vast majority of physician specialty certifications:

The American Board of Medical Specialties (ABMS);

The American Board of Physician Specialties (ABPS); and,

The American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS).

The first two of these organizations will certify M.D.s and D.O.s, while the last certifies osteopathic physicians only.

Amercian Board of Medical Specialties

American Board of Medical Specialties®
Higher standards. Better care.™

Following its formation in 1933, the Advisory Board for Medical Specialties functioned as a federation of individual specialty boards for nearly four decades. In 1970 the organization was restructured, a full time staff hired, and the named changed to the American Board of Medical Specialties (ABMS). The organization's website states that "The primary function of ABMS is to assist its Member Boards in developing and implementing educational and professional standards to evaluate and certify physician specialists."[19] The ABMS officially recognizes twenty-four member boards. These include the following:

- Allergy and Immunology
- Anesthesiology
- Colon and Rectal Surgery
- Dermatology
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Medical Genetics
- Neurological Surgery
- Nuclear Medicine
- Obstetrics and Gynecology
- Ophthalmology
- Orthopaedic Surgery
- Otolaryngology
- Pathology
- Pediatrics

[19] www.abms.org/About_ABMS/who_we_are/aspx

- Physical Medicine and Rehabilitation
- Plastic Surgery
- Preventive Medicine
- Psychiatry and Neurology
- Radiology
- Surgery
- Thoracic Surgery
- Urology

Today, ABMS member boards certify nearly 800,000 physicians in over 150 general specialties and subspecialties. The organization also sponsors the ABMS Research and Education Foundation whose purpose is to support the scientific, scholarly and public education mission and goals of the ABMS.

In 2000, the 24 member boards of the ABMS agreed to evolve their recertification programs to one of continuous professional development called ABMS Maintenance of Certification (MOC). All of its member boards are in the process of implementing their MOC programs.

Contact Information:
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222 North LaSalle Street, Suite 1500, Chicago, IL 60601
Phone: 312-436-2600
www.abms.org

The American Board of Physician Specialties (ABPS), Inc.

American Board of Physician Specialties®

The American Board of Physician Specialties (ABPS) is the third largest nationally recognized physician multispecialty certifying body in the United States, providing board certification to both allopathic (M.D.) and osteopathic (D.O.) physicians. The ABPS has Diplomates in all of the fifty states, the District of Columbia, Puerto Rico, and Canada. The ABPS serves as the certifying body for the American Association of Physician Specialists.

The ABPS is a 501 (c) (6) not-for-profit organization first organized in 1950 for the purpose of providing a clinically recognized mechanism for specialty certification for physicians who had obtained advanced training in various areas of medical specialty. The organization began granting its first certifications in 1960.

At present, the ABPS oversees the administration and development of 12 member boards, representing 18 distinct medical specialties, including:

- Anesthesiology
- Dermatology
- Diagnostic Radiology
- Disaster Medicine
- Emergency Medicine
- Family Medicine Obstetrics
- Family Practice
- General Surgery
- Geriatric Medicine
- Hospital Medicine
- Integrative Medicine
- Internal Medicine
- Obstetrics and Gynecology
- Ophthalmology
- Orthopedic Surgery
- Psychiatry
- Radiation Oncology
- Urgent Care

All of the above specialties require applicants for certification to take both a written and an oral examination, except for Geriatric Medicine, Ophthalmology, Hospital Medicine, Dermatology, Internal Medicine, Urgent Care, Integrative Medicine and Family Practice. Physicians who pass the certification requirements of an ABPS board are considered diplomates in the relevant specialty area.

Contact information:
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American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS)

American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS) is a non-profit umbrella organization for eighteen medical specialty boards in the United States. The AOABOS assists its member boards in developing and implementing educational and professional standards to evaluate and certify physician specialists. The AOABOS was organized in 1939 as the Advisory Board for Osteopathic Specialists in order to promote the certification of osteopathic physicians wishing specialty designation. The name was changed from Advisory Board to Bureau in 1993. At the current time the following are recognized American Osteopathic Association (AOA) Specialty Certifying Boards:

- Anesthesiology (AOBA)
- Dermatology (AOBD)
- Emergency Medicine (AOBEM)
- Family Physicians (AOBFP)
- Internal Medicine (AOBIM)
- Neurology
- Neuromusculoskeletal Medicine (AOBNMM)
- Nuclear Medicine (AOBNM)
- Obstetrics and Gynecology (AOBOG)
- Ophthalmology and Otolaryngology (AOBOO)
- Orthopedic Surgery (AOBOS)
- Pathology (AOBPa)
- Pediatrics (AOBP)
- Physical Medicine & Rehabilitation (AOBPMR)
- Preventive Medicine (AOBPM)
- Proctology (AOBPR)
- Radiology (AOCR)
- Surgery (AOBS)

The AOABOS recognizes primary certification as conferred upon physicians who "meet the requirements in a specified field of medical practice under the jurisdiction of a certifying board". According to the AOABOS, "primary certification represents a distinct and well defined field of osteopathic medical practice". The organization also recognizes subspecialty certification that it calls Certification of Special Qualifications (CSQ). This status is granted to physicians who possess knowledge, skill, training, and successful examination in a subspecialty field over and above that required for primary certification. Furthermore, the AOABOS grants Certification of Added Qualifications (CAQ) which is a "modification of a primary certificate or certificate of special qualifications to reflect additional training of at least one year in length and satisfactory completion of a certifying examination in that field".[20]

As with other certifying organizations, AOABOS recognizes that certification should not be a single event, but rather a continuous and lifelong process. It uses the designation, Osteopathic Continuous Certification (OCC) to indicate its efforts

[20] American Osteopathic Association website at http://www.osteopathic.org/inside-aoa/development/aoa-board-certification/Pages/certification-definitions.aspx

to ensure that board-certified osteopathic physicians maintain currency in their knowledge and skills and demonstrate competency in their specialty area. At the present time, OCC augments the recertification process through the addition of a Practice Performance Assessment. As of January 1, 2013, each osteopathic specialty certifying board developed OCC requirements. The OCC process has five components:

- A requirement for unrestricted licensure
- Ongoing medical education requirements (which vary by board)
- Cognitive assessment via proctored examination to assess medical knowledge and core competencies
- Practice Performance Assessment and Improvement (through comparison of personal practice performance measured against national standards by specialty)
- Continuous membership in the American Osteopathic Association (AOA)

The AOA specialty boards use the terminology 'board eligible' to indicate physicians who have completed their training program in a specialty area but not yet completed the certification process. Board eligible status expires on December 31st of the sixth year after the completion of the training program.

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www.osteopathic.org

The Future of Specialty Certification

Board certification is emerging as a de facto requirement for full participation of physicians in the U.S. health care system. Those who are not certified by some specialty board are becoming an increasingly marginalized group. The willingness to demonstrate ongoing clinical competence through the rigorous examination processes of widely recognized specialty boards is increasingly being seen as an important act of professionalism. Numerous studies have firmly established patient preference for board certified physicians to care for them and their families.[21]

The increased reliance on specialty boards to help establish physician competence comes with reciprocal responsibilities. As the science of testing advances, specialty certification boards are obligated to ensure that their requirements and examinations are meaningful and accurate measures of clinical competence. For patients and professional organizations putting reliance on the work of any particular specialty board, it is important to evaluate the quality of the professional network to which it belongs. This will provide an indication of the rigor and credibility of its work. In these turbulent times in the health care field, 'fly by night' specialty boards may become more and more common to meet the self-serving needs of selected constituencies of doctors. The history of the board certification movement shows that all specialty certification bodies are not created equal. This monograph has been intended to assist those seeking to learn more about this ever-changing world of physician competency assessment through board certification.

[21] Brennan TA, Horowitz RI, Duffy FD, Cassel CK, Goode LD, Lipner RS. The role of physician specialty board certification status in the quality movement. JAMA. 2004; 292(9):1038-1043

Board Certification FAQs:

What is Board Certification?

Board certification of doctors is a voluntary process by which a physician demonstrates at a particular time through written, practical, and/or actual practice or simulator based testing, a mastery of the basic knowledge and skills that define a particular area of medical specialization. In general, an applicant for board certification must have acquired an undergraduate degree and a medical degree (M.D. or D.O.) and completed an accredited residency program (typically three to five years) in an area of specialization.

What is a medical specialty?

A core body of knowledge and skill defines an area of medical specialization. Practitioners exercising this core body of knowledge typically organize themselves into a professional group to define the core competencies for the area of specialization.

What is a Certification Examination?

Physicians seeking board certification in a given area of specialty must successfully complete and pass an examination process designed to test their mastery of the minimum knowledge and skills that characterize the area of specialization. Prior to taking the examination, a physician must graduate with a medical degree, either M.D. or D.O., complete a residency program, and meet all other prerequisites to certification as set out by the certifying agency or "board." Certifying organizations create certification exams after an extensive process to identify the core knowledge and skills that characterize an area of specialization. These organizations also use rigorous educational methodologies to validate the tests they utilize.

What is a Specialty Board?

A specialty board is an organization established by practitioners in a particular specialty to determine the core knowledge and skills that characterize that specialty, to establish criteria to "certify" the competence of practitioners in the specialty, to create and administer tests of knowledge and skill in the specialty area, and to grant 'certification' to practitioners in the specialty.

What is a Diplomate of a Medical Specialty Board?

The term diplomate is generally applied to physicians who have become certified by recognized medical specialty board.

What does Board Eligibility Mean?

Board eligibility is terminology loosely employed by various parties. In general, its intent is to indicate physicians who have completed the requisite education and training for board certification, but have not yet taken the certification exam administered by the relevant specialty board. Many boards allow a window of time following completion of training to successfully pass the certification examination. Most boards limit this time to no more than six or seven years.

What is the difference between a Licensed doctor and a Board Certified doctor?

Every state requires that a physician be licensed by an appropriate state medical board in order to practice medicine in that state. No state currently requires a doctor to be board certified in order to hold an active medical license. Board certification is a voluntary process that goes above and beyond licensing requirements and indicates a doctor's capabilities in a particular specialty. A medical license enables a doctor to treat patients but does not indicate whether that physician is qualified to practice in a specific medical specialty.

What is a Certificate of Added Qualifications (CAQ)?

This terminology is used by many specialty boards to reflect additional training and testing germane to practitioners in one or more specialties. For example, the American Board of

Family Medicine offers a CAQ in geriatric medicine, as does the American Board of Internal Medicine.

What is Maintenance of Certification (MOC)?

Maintenance of Certification is an approach to continuous certification being advocated by some certifying organizations. MOC programs replace periodic recertification with ongoing requirements that include education, professional practice activities, and intermittent testing. Different certifying organizations use different nomenclature for their efforts at continuous certification and each puts a somewhat different emphasis on what assessment elements should comprise ongoing monitoring of competency. The ABMS refers to their activities in this area as 'Maintenance of Certification (MOC)'. The ABPS efforts are referred to as 'Continuous Competency in Certification (CCC)'. The AOA nomenclature for this approach to certification is 'Osteopathic Continuous Certification (OCC)'.

What is a Certificate of Special Qualifications (CSQ)?

This terminology is primarily used by the American Osteopathic Association to indicate subspecialty certification by one of its boards. Subspecialty certification requires prior attainment of general certification in a "distinct and well defined field of osteopathic medical practice".

How Do Individuals or Organizations Verify a Physician's Certification Status?

The major certifying bodies provide online resources to ascertain a physician's certification status with that organization. This allows hospitals and other credentialing bodies to have an expeditious means for primary source verification of the board certification of applicants for staff membership and privileges. The websites for the three largest multi-specialty certifying organizations are:

www.abms.org
www.abpsus.org
www.osteopathic.org

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About the Author

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Todd Sagin, M.D., J.D., is a physician executive recognized across the nation for his work with hospital boards, medical staffs, and physician organizations. He is the national medical director of Sagin Healthcare Consulting, LLC and HG Healthcare Consultants, LLC, which provide guidance on a wide range of health care issues.

Dr. Sagin is a popular lecturer, consultant, mediator, and advisor to health care organizations. He is frequently asked to assist hospitals and physicians develop strong working relationships, as healthcare becomes a more integrated enterprise. Over the past decade he has been engaged by several hundred of the nation's hospitals to work with their governing boards, medical staffs, and management teams to improve the quality of the care they deliver. This work ranges from leadership education to strategic planning, from strengthening medical staff affairs to creating new integration structures to bring hospitals and physicians together.

Dr. Sagin is a regular faculty member for organizations such as The Governance Institute, the American College of Physician Executives, and the American College of Healthcare Executives. In 2012 he was appointed to the Baldridge Board of Examiners which surveys healthcare institutions to recognize exemplary quality performance.

Dr. Sagin is board certified in family medicine and geriatrics and has taught and practiced in community hospital and university settings. He currently practices at Community Volunteers in Medicine in West Chester, PA.

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Dr. Sagin is a popular public speaker and his teaching won him the Golden Apple teaching award at Temple University School of Medicine. He frequently facilitates board and medical staff retreats and delivers leadership education to physicians and to health system trustees and executives. He has written widely on matters ranging from peer review and credentialing to health care integration. Dr. Sagin can be reached at TSagin@SaginHealthcare.com.

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